89- 1400

Supreme Court, U.S.
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NO.

IN THE

**Supreme Court of the United States**

October Term, 1989

CITY OF LONGMONT COLORADO,

Petitioner

v.

JAMES OAKLEY

Respondent

**PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT**

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To the Honorable Chief Justice and Associate Justices of the Supreme Court of The United States:

The City of Longmont, Colorado, Petitioner herein, prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Tenth Circuit entered in this case on December 8, 1989.

**QUESTIONS PRESENTED FOR REVIEW**

A. Pursuant to 42 U.S.C. § 300bb-2, where a terminated employee, covered under his employer's group health plan, is also covered under a group health plan provided by his spouse's employer and remains covered under the spouse's plan after electing so-called continuation coverage from his former employer's plan, must his

former employer extend continuation coverage?

B. Are United States Treasury Department proposed Regulations, which expressly state that "continuation coverage" may be terminated upon the "first date after the date of election upon which the qualified beneficiary is covered . . . under any other group health plan that is not maintained by the employer..." entitled to judicial deference, as a reasonable interpretation of the statute?

**PARTIES IN THE LOWER COURTS**

Parties to the proceedings in the Court of Appeals for the Tenth Circuit United States Court of Appeals were:

1. City of Longmont Colorado; and
2. Safeco Insurance Company of America

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**PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT**

**OPINIONS BELOW**

The opinion of the United States District Court for the District of Colorado, filed December 19, 1988 is, reported as Oakley v. City of Longmont, 701 F.Supp. 800 (D.Colo. 1988). The Opinion of the Panel of the United States

Court of Appeals for the Tenth Circuit, filed October 6, 1989, and since withdrawn, was reported as Oakley v. City of Longmont, 887 F.2d 249 (10th Cir. 1989). The Substituted Opinion of the same Panel of the United States Court of Appeals for the Tenth Circuit on Petition for Rehearing, filed December 8, 1989 is reported as Oakley v. City of Longmont, 890 F.2d 1128 (10th Cir.1989).

**SUPREME COURT JURISDICTION**

The Order on Petition for Rehearing of the Tenth Circuit Panel withdrawing the Court's first Opinion, Oakley v. City of Longmont, 887 F.2d 249 (10th Cir.1989) and substituting the second Opinion, Oakley v. City of Longmont, 890 F.2d 1128 (10th Cir.1989) was filed and entered December 8, 1989. The jurisdiction of this Court

is invoked pursuant to 28 U.S.C. § 1254 (1).

**STATUTES AND REGULATIONS INVOLVED**

42 U.S C. §§ 300bb-1 through 300bb-8 (reproduced in Appendix, page 69a)

Proposed Rules, Department of the Treasury, Internal Revenue Service, Income Tax; Continuation Coverage Requirements of Group Health Plans, 52 Fed.Reg. 22716 (1987) (to be codified at 26 C.F.R. § 1.162-26) (reproduced in appendix, page 81a)

**STATEMENT OF THE CASE**

**A. Statement of Facts**

The pertinent facts, as contained in the District Court's MEMORANDUM OPINION AND ORDER, Oakley v. City of Longmont, 701 F.Supp. 800, 800-801 (D.Colo. 1988)

(appendix, pages 2a through 4a), are as follows:

> "On June 12, 1987, plaintiff [James Oakley] was seriously injured in a car accident. At that time, plaintiff was a fire fighter for the City and covered under its group health plan. After plaintiff exhausted his accrued sick leave and vacation days, together with the maximum 90 days of temporary disability leave (which the City extended twice so that plaintiff could continue receiving medical benefits), plaintiff was placed on leave without pay for one year. On August 27, 1988, when it was apparent that plaintiff's disability

was permanent, preventing performance of his job, the City terminated plaintiff's employment. The City maintained plaintiff's health coverage until his termination. Then, pursuant to the plan, the City afforded plaintiff the right to maintain coverage at group rates for 90 days (through November 26, 1988).

On October 7, 1988, the City sent plaintiff notice of his right to elect continuation coverage pursuant to 42 U.S.C. § 300bb-1 and §300bb-5. To date [of the Trial Court's decision], plaintiff has not returned the form electing continuation coverage.

> At the time of plaintiff's termination, he became, and remains a covered dependant under his wife's group health plan. Because plaintiff has not yet elected continuation coverage, and because he is a dependant under his wife's policy, the City has not extended the plaintiff continuation coverage."

**B. Procedural History**

Oakley sued for a declaratory judgment that he was entitled to so-called "continuation coverage" under Longmont's group health plan, pursuant to 42 U.S.C. § 300bb-1. Longmont answered, denying that the Oakley was entitled to coverage. On cross motions for summary judgment, the District Court denied the Oakley's motion

for summary judgment, and granted Longmont's. Oakley appealed that order.

The Tenth Circuit panel reversed, in its first opinion, dated October 6, 1989 (Appendix, page 13a). On December 8, 1989, the same panel, in response to Longmont's Petition for Rehearing, withdrew the first opinion and substituted a new one, Oakley v. City of Longmont, 890 F.2d 1128 (10th Cir.1989) (Appendix, pages 40a and 42a), again reversing the District Court. According to the Tenth Circuit Panel,

> "...the plain meaning of [42 U.S.C. § 300bb-2(2)(D)(i)] cannot be construed to include a spouse's preexisting group plan as a condition to terminate continuation

coverage. Indeed, Mr. Oakley did not 'first become' covered under his wife's policy after the qualifying event that resulted in his termination from the City's employment. Nor did Congress intend a covered employe's termination to become a condition triggering 'other' coverage under the spouse's preexisting health plan. Consequently, only when we read the language of subsection (i) to refer to other coverage occurring after the qualifying event, do we preserve its plain meaning and give effect to Congress' intent." Substituted Panel Opinion, December 8, 1989, 890 F.2d at 1132 (appendix, page 58a).

Longmont's Suggestion for Rehearing en banc was denied on January 25, 1990 (appendix, page 66a).

Jurisdiction in the United States District Court for the District of Colorado was pursuant to 28 U.S.C. § 1331 and 42 U.S.C. § 300bb-7. Jurisdiction of the Tenth Circuit United States Court of Appeals was pursuant to 28 U.S.C. § 1291.

## REASONS FOR GRANTING THE WRIT

### I. THIS CASE INVOLVES A SIGNIFICANT ISSUE.

This case involves the correct application, in a case of first impression, of the Group Health Plan "Continuation Coverage" Requirements of the Comprehensive Omnibus Budget

Reconciliation Act of 1986, Public Law 99-272, 100 Stat. 82, (1986) (COBRA). The statute affects public and private employers throughout the country and requires that they extend group health plan "continuation coverage" for up to 18 months after a "qualifying event" (in this case termination of employment).[1] The

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[1] Title X of the Comprehensive Omnibus Budget Reconciliation Act of 1986, Public Law 99-272, 100 Stat. 82, (1986) (COBRA), as amended by the Tax Reform Act of 1986, Pub. L. 99-514, 100 Stat. 2938 (1986), enacted a federal requirement that certain group health plans provide "continuation coverage" to each "qualified beneficiary" who, but for the statute, would lose coverage. Section 10001 of the Act amended subsection (i) of Section 162 of the Internal Revenue Code of 1954 (26 U.S.C. § 162) to disallow certain tax deductions for group health plans that do not provide the required continuation coverage.

Section 10002 makes corresponding amendments to the Employee Retirement Income Security Act of 1974. Section

statute has a substantial financial impact on public and private employers and, except for the decision appealed herein, has not been construed by a Federal Appellate Court. The Tenth Circuit decision invalidates an interpretative regulation issued by the Treasury, creating substantial uncertainty among employers attempting to understand and comply with the law.

II. THE TENTH CIRCUIT'S INTERPRETATION OF THE STATUTE IS INCONSISTENT WITH THE MANIFEST INTENT OF CONGRESS.

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10003 enacts Title XXII of the Public Health Service Act, to generally subject state and local government group health plans to requirements that parallel those of Sections 10001 and 10002. These amendments to the Public Health Service Act are codified at 42 U.S.C. § 300bb-1 through 300bb-8 (Appendix, page 66a).

The Senate Finance Committee Report on COBRA, appears at S. REP. NO. 146, 99th Cong., 1st Sess. (October 2, 1985), reprinted in 1986 U.S. CODE CONG. & AD. NEWS 251, et seq. (1986). At page 363 of the report [1986 U.S. CODE CONG. & AD. NEWS 322 (1986)], the Committee states the reasons for recommending the continuation coverage requirements as follows:

> "The Committee was concerned that certain spouses and dependent children may be deprived of health benefits due to an unexpected change in family status. To provide an opportunity for these individuals to secure health benefits, the Committee believes it is appropriate

to require that employer group health plans offer qualified beneficiaries an election to continue coverage for a limited period of time." (Emphasis added).

Illustrative of the Congressional intent that continuation coverage be limited only to the time that it is actually necessary to provide some basic level of health benefits is the language in the Finance Committee's report (S. REP. NO. 146, 99th Cong., 1st Sess. (1985), supra) at page 365 (3 U.S. CODE CONG. & AD. NEWS 324 (1986)) :

"This 18-month period includes, and is not in addition to, any continuation period presently permitted by the Plan or required under local law."

The House Report on COBRA provides, in pertinent part:

> "The Committee is concerned with reports of the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay. Since 1977, the number of Americans without any health insurance coverage has increased by 40%, from twenty-five million people to thirty-five million people, according to a study conducted by the Department of Health and Human Services.
>
> Many of those without health insurance coverage are family

members of deceased, divorced, or Medicare-eligible workers. Most individuals covered by health insurance have access to that insurance through employment. Workers often cover their spouses and minor children through dependent coverage. Although dependent coverage is more expensive than individual coverage, the group rates available through the worker's employer have made broad health care coverage affordable to most American families.

Few employers, however, extend the benefit of group coverage to spouses and dependent family members when the worker dies, when the spouse's relationship to the worker

is severed through divorce, or when the worker becomes eligible for Medicare.

In those instances, the spouse or former spouse is often forced either to seek health insurance at individual rates or forgo insurance completely...." , H.R. Rep. No. 300, 99th Cong., 1st Sess. 308 (October 3, 1985) , reprinted in 1986 U.S.CODE CONG. & AD. NEWS 756,959 (emphasis added)

Thus, it is clear that Congress sought to provide protection only for a "limited period of time" to those who, otherwise would be "without any health insurance coverage" and would have to "forgo insurance completely". James Oakley,

however, has other health insurance and need not forgo insurance completely.

## III. THE PHRASE, "AFTER THE DATE OF ELECTION" IN 42 U.S.C. § 300bb-1(2)(D) MERELY REFLECTS THE MANNER IN WHICH THE STATUTE OPERATES.

42 U.S.C. § 300bb-2 sets out the minimum requirements for continuation coverage (if it is timely elected). Paragraph (1) describes the kind of benefits that must be provided and paragraph (2) establishes the required minimum and maximum periods of coverage. Generally continuation coverage must begin on the date of the qualifying event and may end not earlier than the earliest of several listed dates: the "Maximum

required period" (generally 18 or 36 months after the date of the qualifying event) [Subparagraph (2)(A)]; "End of plan" [Subparagraph (2)(B)]; "Failure to pay premium" [Subparagraph (2)(C)]; or "Group health plan coverage or medicare eligibility" [Subparagraph (2)(D)].

Subparagraph (2)(D), which is the subject of this litigation, reads, in pertinent part, as follows:

> "(D) Group Health Plan Coverage or Medicare Eligibility. The date on which the qualified beneficiary first becomes, <u>after the date of election</u>-
>
> (i) Covered under <u>any</u> other group health plan (<u>as an employee or otherwise</u>). . .
>
> (emphasis added)

The Tenth Circuit Opinion holds that the statutory phrase, "after the date of election", means that pre-existing coverage under another group plan cannot support early termination. But correctly viewed, the underlined phrase merely reflects the manner in which the statute operates.

42 U.S.C. § 300bb-1 states the basic requirements of the Act: Each group health plan maintained by a political subdivision shall provide:

> "that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the

plan." (emphasis added) 42 U.S.C. § 300bb-1

Thus, before the employer must provide continuation coverage, there must first be an election within the "election period" [generally 60 days after notice or termination of coverage by reason of a qualifying event, 42 U.S C. § 300bb-5(1)]. Under this scheme, there can be no right to continuation coverage and, therefore, no question of when such coverage may be terminated until the employee first elects it. Logically, there is no need to address when continuation coverage may be terminated by other coverage until "after the date of election". This phrase merely reflects the manner in which the statute operates and reflects no intent to exempt

preexisting coverage from the "other group health plan" early termination provisions.

## IV. THE TENTH CIRCUIT OPINION INCORRECTLY IGNORES THE CONTEMPORANEOUS CONSTRUCTION PLACED UPON THE STATUTE BY THE AGENCY CHARGED WITH ITS INTERPRETATION.

The Treasury Department, charged with enforcing the requirements of the Act, has interpreted the "other group health plan" termination provisions quite narrowly, in favor of early termination. According to the Department, continuation coverage may terminate on:

> ". . . the first date after the date of the election upon which the qualified beneficiary <u>is</u> <u>covered</u> (i.e., actually covered, rather than

merely eligible to be covered) under any other group health plan that is not maintained by the employer, even if that other coverage is less valuable to the qualified beneficiary than COBRA continuation coverage (e.g. if the other coverage provides no benefits for preexisting conditions);" Proposed Rules, Department of the Treasury, Internal Revenue Service, Income Tax; Continuation Coverage Requirements of Group Health Plans, 52 Fed.Reg. 22716, 22730 (1987) (to be codified at 26 C.F.R. § 1.162-26) (Emphasis added) (Appendix, page 95a)

Thus, the interpretive regulations recognize that Congress intended to allow

early termination of continuation coverage upon "the first date after the date of the election upon which the qualified beneficiary is covered ...under any other group health plan " (emphasis added).

The contemporaneous construction of a statute by an administrative agency charged with its execution should be followed unless there are compelling indications that it is wrong, Chemical Manufacturers Association v. Natural Resources Defense Council Inc., 470 U.S. 116, 105 S.Ct. 1102, 4 L.Ed. 2d 90 (1985); United States v. Turkette, 452 U.S. 576, 101 S.Ct. 2524, 69 L.Ed. 2d 246 (1981); E.I. du Pont de Nemours and Company v. Collins Co. , 432 U.S. 46, 97 S.Ct. 2229, 53 L.Ed. 2d 100 (1977). Both the available legislative history and the

contemporaneous construction of the statute by the Treasury reflect an intent to require continuation coverage only for so long as is actually necessary to afford some minimal level of coverage, regardless of the relative value of that coverage, to qualified beneficiaries who would otherwise have no coverage of any sort. The statute and regulations are devoid of any indication that Congress intended to require continuation coverage for qualified beneficiaries who are also covered by another plan.

The Tenth Circuit Opinion holds that the interpretative regulations, which clearly provide that continuation coverage may be terminated in the circumstances of this case, are not persuasive because they are only proposed, rather than final

regulations and, in support cites dictum in a footnote to a 1980 4th Circuit decision, Telvest, Inc. v. Bradshaw, 618 F.2d 1029, 1032 n. 10 (4th Cir.1980).

But the correct rule is that even a proposed regulation is entitled to deference in statutory construction, if it represents the interpretation of the statute given by the agency charged with its interpretation, United States Steel v. United States, 618 F.Supp. 496, (U.S. Ct. Int'l Trade 1985). "The form in which an agency manifests its interpretation of a statute it administers is immaterial; the critical thing is whether there is such an interpretation and how settled it has become.", First Multifund for Daily Income, Inc. v. United States, 602 F.2d 332, 337; 221 Ct.Cl.123 (Ct. Cl. 1979),

cert.den. 445 U.S. 916, 100 S.Ct. 1275, 63 L.Ed.2d 599.

Regarding the proposed regulations in this case, the Treasury Department has stated:

> "For the period before the effective date of final regulations, the Internal Revenue Service will consider compliance with the terms of these proposed regulations to constitute good faith compliance with a reasonable interpretation of the statutory requirements. . . " 52 Fed.Reg. 22716 (June 15, 1987) (appendix page 89a) (Emphasis added).

Moreover, the conference report accompanying the statute provides, in pertinent part, that:

"To avoid the issuance of duplicate and perhaps inconsistent regulations, the conferees authorized . . . the Secretary of Treasury to issue regulations defining required coverage. . . The conferees intend that any regulations issued by the Secretary of Health and Human Services will conform (in terms of actual requirements) with those regulations issued by the Secretary of the Treasury. . ." H.R. REP. No. 453, 99th Cong., 1st Sess. pp. 562-563, (December 19, 1985) reprinted in 131 CONG. REC. 38124, 38286 (1985)(emphasis added).

Thus, Congress clearly intended the Treasury Department regulations to govern

interpretation of the statute regarding the extent of the required coverage, including the conditions under which continuation coverage may be terminated early. The Tenth Circuit Opinion incorrectly ignores the contemporaneous legislative construction placed upon the statute by the agency charged with its interpretation.

V. THE ISSUE POSED BY THIS CASE IS NOT THE REQUIRED SCOPE OF "CONTINUATION COVERAGE" UNDER 42 U.S.C. § 300bb-2(1), BUT RATHER WHEN THAT COVERAGE MAY BE TERMINATED UNDER §300bb-2(2)(D)(I).

The Tenth Circuit Opinion misconstrues the issue in this case. According to the Tenth Circuit decision,

> "The essence of continuation coverage . . . is that coverage must be 'identical' not only to that coverage which the employee had prior to the qualifying event, but also to 'the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.' 42 U.S.C.

§300bb-2(1)." 890 F.2d 1133 (Tenth Circuit Opinion, appendix, page 62a).

However, the issue posed by this case is not the required scope of "continuation coverage" under 42 U.S.C. §300bb-2(1), but when that coverage may be terminated under §300bb-2(2)(D)(i).

Longmont agrees that continuation coverage (until terminated) must be identical to coverage provided to City of Longmont employees under the plan. But this begs the real question: Is the employer required to extend continuation coverage? Nothing in the statute conditions early termination of continuation coverage upon identical coverage under the "other group health plan" and the interpretative

regulations expressly eschew such a requirement.

## VI. CONGRESS DID NOT INTEND TO DISTINGUISH, FOR PURPOSES OF EARLY TERMINATION OF CONTINUATION COVERAGE, BETWEEN THE SPOUSE OF A COVERED EMPLOYEE AND OTHER QUALIFIED BENEFICIARIES.

The Tenth Circuit Opinion finds, in the language of the statute, a nonexistent distinction between the treatment Congress intended for a "covered employee" and for other "qualified beneficiar[ies]":

> "While the district court believed "or otherwise" included the then-existing coverage of the employee's spouse, Congress intended this language to refer to subsequent

events related to the employee's own employment or marital status." 890 F.2d at 1132 (Appendix, page 61a).

As originally enacted, the statute did draw a distinction between the spouse of a covered employee and other types of qualified beneficiaries, see Title XXII, §2202, Pub.L. 99-272, 100 Stat. 233 (1986), but this distinction was eliminated by the Tax Reform Act of 1986, Pub.L. 99-514, § 1895(4), 100 Stat. 2937 (1986).

Public Law 99-514 eliminated paragraph (2)(E), 42 U.S.C. § 300bb-2, which contained a special provision for early termination "in the case of an individual who is a qualified beneficiary by reason of being a spouse of a covered employee", and expanded the coverage of subparagraph

(2)(D)(I) to include "qualified beneficiaries" who are "covered under any other group health plan (as an employee or otherwise)" (emphasis added). The statute expressly defines "qualified beneficiary" to include a terminated "covered employee", 42 U.S.C. § 300bb-(3)(B).

Thus, as the statute read at the time of the events at issue in this case, Congress clearly did not intend to distinguish, for purposes of early termination of continuation coverage, between the spouse of a covered employee and other kinds of qualified beneficiaries. Rather the clear intent was to enact one rule for early termination as to any and all qualified beneficiaries who are covered under any other group health plan, whether covered

as an employee or otherwise. The assertion that "Congress intended this language to refer to subsequent events related to the employee's own employment or marital status.", is unsupported by the plain text or legislative history of the statute.

VII. THE INTERPRETATION ADOPTED BY THE TENTH CIRCUIT IS INCONSISTENT WITH THE MANIFEST PURPOSE OF THE ACT AND LEADS TO AN ILLOGICAL, EVEN ABSURD RESULT.

In interpreting legislation, absurd results are to be avoided, United States v. Turkette, supra. But, the interpretation given by The Tenth Circuit leads to an illogical, even absurd result.

Under its reading of the statute, the employer could terminate coverage early where the employee was not covered under his spouse's plan on the date of election but became covered by another plan less than eighteen months thereafter. But if, as in this case, the employee were covered by two plans on the date of election, (and current medical problems were, therefore, not excluded under the spouse's plan as a preexisting condition), the employer must extend coverage for the full 18-month period. This creates an absurdity; One with an apparently greater need for continuation coverage (covered by only one plan on the date of election) would be afforded less protection than one with less need (covered under two health plans on the date of election).

The Tenth Circuit Opinion also yields an absurd result when one considers that a "qualified beneficiary" (including a "covered employee") may elect continuation coverage at any time within sixty days after termination of coverage or notice of the right to elect, 42 U.S.C. § 300bb-5(1). According to the Tenth Circuit's logic, a covered employee terminated from employment could, within the sixty day election period, obtain other employment and coverage under the group health plan of a second employer. So long as the employee delays election of COBRA continuation coverage from his first employer until after he becomes covered by the group health plan of his second employer, the first employer cannot terminate COBRA continuation coverage,

even if the second employer's plan duplicates the coverage of the first. It is absurd to believe that Congress intended to reward and promote such fringe benefit gamesmanship among employees.

It is more reasonable to conclude that Congress, consistent with its statement of intent and contemporaneous construction of the statute by the Treasury, intended only a "limited" right to continuation benefits, to protect qualified beneficiaries who otherwise would have no coverage of any sort, see Senate Finance Committee Report on COBRA, (S. REP. NO. 146, 99th Cong., 1st Sess. (1985), supra). The statute and available aids to interpretation clearly demonstrate that Congress did not intend to mandate

continuation coverage where there is another source of basic health insurance.

## CONCLUSION

Congress sought to provide protection only for a "limited period of time" to those who, otherwise would be "without any health insurance coverage" and would have to "forgo insurance completely". It did not intend to require employers to provide continuation coverage to beneficiaries who are also covered by another group health plan. To the contrary, Congress intended to allow early termination of continuation coverage on the first date after election that the beneficiary has "Group Health Plan Coverage or Medicare Eligibility"

regardless of whether coverage under the other plan predates election of continuation coverage. The phrase "after the date of election" does not express a contrary Congressional intent; rather, it merely reflects Congressional recognition that, under the statutory scheme, early termination of continuation coverage can only occur after an election of such coverage.

The Tenth Circuit decision should be reversed, and the case remanded with instructions to affirm the District Court decision.

Dated February 26, 1990

Respectfully submitted,

Claybourne M. Douglas

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Attorney for Petitioner,
City of Longmont

## CERTIFICATE OF SERVICE

I, Claybourne M. Douglas, City Attorney for the City of Longmont, Colorado, Petitioner herein and a member of the Bar of the Supreme Court of the United States, hereby certify that on the _____ day of _____, 1990, I served copies of the foregoing Petition for Writ of Certiorari on SAFECO Insurance Company of America and Respondent, James Oakley, by depositing three copies each of the enclosed Petition for Writ of Certiorari in the United States Post Office located at 201 Coffman Street, Longmont, Colorado, with first class postage prepaid, and properly addressed to their counsel of record:

Mark E. Biddison
Stevens and Littman
1881 9th Street, Suite 335
Boulder, Colorado 80302
Telephone: (303) 443-6690
Attorney for Respondent James Oakley

Robert M. Baldwin
Long & Jaudon
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Telephone: (303) 832-1122
Attorney for SAFECO Insurance
Company of America

All parties required to be served have been served.

Claybourne M. Douglas
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408 3rd Avenue
Civic Center Complex
Longmont, Colorado 80501
Telephone: (303) 651-8619

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLORADO**

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|---|---|
| Case No. 88-B-1204. ) | FILED |
| ) | Dec. 19, 1988. |
| James OAKLEY, ) | United States |
| Plaintiff, ) | District Court |
| ) | Denver, Colorado |
| v. ) | |
| ) | |
| CITY OF LONGMONT, ) | |
| and Safeco Insurance ) | |
| Company of America, ) | |
| Defendant ) | |
| ) | |
| ) | |
| ) | |

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MEMORANDUM OPINION AND ORDER

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This matter is before the Court on cross motions for summary judgment regarding the correct interpretation of 42 U.S.C. § 300bb-1 (Subchapter XX--Requirements for Certain Group Health Plans for Certain State and Local Employees--"continuation coverage"). The

narrow issue presented is whether the plaintiff, James Oakley, is entitled to continuation coverage under the City of Longmont's Health Plan (the plan). I conclude that the City of Longmont (the City) is not required to provide plaintiff with continuation coverage and is therefore entitled to summary judgment pursuant to Fed.R.Civ.P. 56.

The material facts are undisputed:

On June 12, 1987, plaintiff was seriously injured in a car accident. At that time, plaintiff was a firefighter for the City and covered under its group health plan. After plaintiff exhausted his accrued sick leave and vacation days, together with the maximum 90 days of temporary disability leave (which the City extended twice so that plaintiff could

continue receiving medical benefits), plaintiff was placed on leave without pay for one year. On August 27, 1988, when it was apparent that plaintiff's disability was permanent, preventing performance of his job, the City terminated plaintiff's employment. The City maintained plaintiff's health coverage until his termination. Then, pursuant to the plan, the City afforded plaintiff the right to maintain coverage at group rates for 90 days (through November 26, 1988).

On October 7, 1988, the City sent plaintiff notice of his right to elect continuation coverage pursuant to 42 U.S.C. § 300bb-1 and § 300bb-5. To date, plaintiff has not returned the form electing continuation coverage.

At the time of plaintiff's termination, he became, and remains, a covered dependant under his wife's group health plan. Because plaintiff has not yet elected continuation coverage, and because he is a dependent under his wife's policy, the City has not extended the plaintiff continuation coverage.

Plaintiff contends that his status as a covered dependent under his wife's health plan does not terminate his right to continuation coverage under the City's health plan. I disagree.

42 U.S.C. § 300bb-1 states the basic requirements for state and local governmental group health plans. It provides "that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is

entitled, under the plan, to elect, within the election period, continuation coverage under the plan." Termination is a qualifying event that triggers operation of the statute. 42 U.S.C. § 300bb-3(2). In addition, where, as here, the covered employee has been terminated, he is a qualified beneficiary under the statute. 42 U.S.C. § 300bb-8(3)(B).

Continuation coverage generally must be provided for 18 months immediately following the qualifying event. 42 U.S.C. § 300bb-2(2). However, subparagraph 2(D), which is the subject of this litigation, provides for early termination of benefits. It states:

> (2) Period of coverage
>
> The coverage must extend for at least the period beginning on the

date of the qualifying event and ending not earlier than the earliest of the following:

(D) Group health plan coverage or medicare eligibility

The date on which the qualified beneficiary first becomes, after the date of the election--

(i) covered under <u>any</u> other group health plan (as an employee <u>or otherwise</u> ), or

(ii) entitled to benefits under (Medicare.)."(emphasis added).

The legislative history of 42 U.S.C. § 300bb-1 and 2 reflects that the purpose of continuation coverage is to provide health benefits to qualified beneficiaries who otherwise would have no coverage of any sort rather than to provide overlapping,

dual coverage. The Senate Finance Committee's report on the recommended continuation coverage requirements states:

> "The committee was concerned that certain spouses and dependent children may be deprived of health benefits due to an unexpected change in family status. To provide an opportunity for these individuals to secure health benefits, the Committee believes it is appropriate to require that employer group health plans offer qualified beneficiaries an election to continue coverage for a limited period of time." Pub.L. No. 99-272, 3 U.S.CODE CONG. & AD.NEWS 42, 322, 363 (1986).

Furthermore, the Internal Revenue Service (IRS), the administrative agency charged with enforcing the statute, has stated that continuation coverage may terminate on:

> "... the first date after the date of the election upon which the qualified beneficiary is covered (i.e., actually covered, rather than merely eligible to be covered) under any other group health plan that is not maintained by the employer, even if that other coverage is less valuable to the qualified beneficiary ... (e.g., if the other coverage provides no benefits for preexisting conditions) ..." 52 Fed.Reg. 22716, 22730 (June 15, 1987). (emphasis added).

The contemporaneous construction of a statute by an administrative agency charged with its execution should be followed unless there are compelling indications that it is wrong. E.I. du Pont de Nemours and Company v. Collins, 432 U.S. 46, 55, 97 S.Ct. 2229, 2234, 53 L.Ed.2d 100 (1977), See also United States v. Turkette, 452 U.S. 576, 101 S.Ct. 2524, 69 L.Ed.2d 246 (1981). Both the available legislative history and the IRS' contemporaneous construction of the statute reflect the beneficent purpose of requiring a minimal amount of continuation coverage for a limited time to provide qualified beneficiaries an opportunity to secure other health benefits. Neither the statute nor the regulations, however, contain any indication that Congress

intended to require employers to provide continuation coverage to qualified beneficiaries who are covered by more than one group health plan.

I conclude that the statute was not intended to require employers to provide overlapping continuation coverage. Assuming, arguendo, that plaintiff had elected continuation coverage within the election period, the City would not be required to provide him with the requested continuation coverage under the statute because plaintiff is "otherwise" covered under "any other group health plan" as his wife's dependant. And, this is so even though coverage under his wife's health plan may be less valuable than under the City's health plan. See 52 Fed.Reg. 22716, 22730 (June 15, 1987).

Accordingly, because, as a matter of law, the City is not required to provide him with continuation coverage, defendant is entitled to summary judgment on plaintiff's first claim for declaratory and injunctive relief under 42 U.S.C. § 300bb-1.

The sole remaining claim is a pendent state claim for continuation benefits under § 10-8-116(13)(a), C.R.S. (1987 Repl.Vol. 4A). Circumstances that would warrant exercise of pendent jurisdiction under United Mine Workers v. Gibbs, 383 U.S. 715, 86 S.Ct. 1130, 16 L.Ed.2d 218 (1966), are not present here. Therefore, plaintiff's second claim for relief will be dismissed without prejudice.

Therefore, it is ordered that defendant's motion for summary judgment is

granted and plaintiff's motion for summary judgment is denied. It is further ordered that plaintiff's second claim for relief be dismissed without prejudice. Each party shall bear their own costs.

BY THE COURT:December 19,1988

LEWIS T. BABCOCK, District Judge.

**PUBLISH**

**UNITED STATES COURT OF APPEALS**

**FOR THE TENTH CIRCUIT**

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|---|---|
| JAMES OAKLEY, Plaintiff-Appellant, v. CITY OF LONGMONT and SAFECO INSURANCE COMPANY OF AMERICA, Defendants-Appellees. | FILED United states Court of Appeals Tenth Circuit October 6, 1989 Robert L. Hoecker Clerk<br><br>No. 89-1021 |

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Appeal from the United States
District Court
For the District of Colorado
D.C. No. 88-B-1204

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Submitted on the Briefs:

Mark E. Biddison and Andrew C. Littman of Stevens, Littman & Biddison, Boulder, Colorado, for Plaintiff-Appellant.

Claybourne M. Douglas, City Attorney, for Defendant-Appellee city of Longmont.

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Before **MOORE**, **ANDERSON**, and **BRORBY**, Circuit Judges.

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**MOORE**, Circuit Judge.

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After examining the briefs and appellate record, this panel has determined unanimously that oral argument would not materially assist the determination of this appeal. See Fed. R. App. P. 34(a); 10th Cir. R. 34.1.9. The cause is therefore ordered submitted without oral argument.

James Oakley sought a declaratory judgment that he was entitled to continue his medical insurance coverage under the health plan offered by his employer, the City of Longmont (the City), after he was

severely injured in an automobile accident. Resolving cross-motions for summary judgment, the district court granted the City's motion, finding that under 42 U.S.C. § 300bb-2(2)(D)(i), the City is not required to provide continuation coverage to its previously covered employee. Oakley v. City of Longmont, 701 F.Supp. 800 (D. Colo. 1988). We reverse.

I.

Mr. Oakley was employed by the City as a fire fighter when he was involved in an automobile collision with a drunk driver and suffered a permanent head injury. As a City employee, Mr. Oakley was covered by the City of Longmont Medical and Dental Care Expense Reimbursement Plan, Plan No. 56690 (the Plan), which extended coverage

until his termination on August 27, 1988, and for an additional ninety days until November 26, 1988, as provided by the Plan. In July 1988, after an exchange of letters, the City informed Mr. Oakley that he was not eligible to maintain his medical insurance coverage for an additional eighteen months with the City's Plan because he is a dependent under his wife's group health plan. Nevertheless, on October 7, 1988, the Plan notified Mr. Oakley of his option to continue his prior medical coverage for eighteen months by maintaining the premium payments himself. Apparently, Mr. Oakley did not return the election form at that time because of his

prior notification that he was ineligible for continuation coverage.

At the time of his termination, Mr. Oakley was a patient at the Bear Creek Rehabilitation Center where he was receiving rehabilitation therapy for the brain injury he had suffered. Although he was listed as a dependent on his wife's group health plan, Mrs. Oakley's coverage does not reimburse the costs of this treatment. Consequently, Mr. Oakley sought declaratory and injunctive relief to continue his medical coverage with the City.

The district court, however, denied relief under 42 U.S.C. § 300bb-2(2)(D)(i),

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[1] Mr. Oakley later returned the form, and the City does not contest his eligibility on this basis.

which states that continuation coverage ends on the date "the qualified beneficiary first becomes, after the date of the election -- (i) covered under any other group health plan (as an employee or otherwise). . . ." The court cited accompanying congressional history which it believed manifested Congress' "beneficent purpose of requiring a minimal amount of continuation coverage for a limited time to provide qualified beneficiaries an opportunity to secure other health benefits." 701 F.Supp. at 801-02. However, relying principally on language in a proposed regulation promulgated by the Internal Revenue

Service,[2] which was delegated the authority to enforce the statute, the court concluded that Congress did not intend "to require employers to provide continuation coverage to qualified beneficiaries who are covered by more than one group health plan." Id. at 802. Mr. Oakley now appeals this conclusion, contending the court erred in construing the statute and in relying on a proposed

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[2] The proposed regulation states that continuation coverage must not end before "(d) the first date after the date of the election upon which the qualified beneficiary is covered (i.e., actually covered, rather than merely eligible to be covered) under any other group health plan that is not maintained by the employer, even if that coverage is less valuable to the qualified beneficiary than COBRA continuation coverage (e.g., if the other coverage provides no benefits for preexisting conditions). . . ." 52 Fed.Reg. 22730 (1987).

Treasury Regulation that has not yet been adopted.[3]

II.

In 1986, Congress passed the Comprehensive Omnibus Budget Reconciliation Act, Pub. L. No. 99-272, 100 Stat. 82 (1986) (COBRA), to address the "staggering budget deficits now facing the United States." S. Rep. No. 99-146, 99th Cong., 2d Sess. 3, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 43. conflated with its many revenue-related provisions is the statute at issue, 42 U.S.C. § 300bb-1, entitled "Requirements for certain group health plans for certain state and local employees." Section

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[3] Safeco Insurance Company of America is not a party to this appeal but has stipulated to being bound by the court's order.

300bb-1 was spawned by Congress' concern "with reports of the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay." H.R. Rep. No. 99-241, Part I, 99th Cong., 2d Sess. 3, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 622. As one solution to the problem, Congress amended Section 162 of the Internal Revenue Code "to deny the business tax deduction for a group health plan of any employer who fails to include in the plan a continuation option" to the employee, his spouse, and dependent children. Id. Congress fashioned the tax incentive to insure that health benefits for certain workers would not be put at risk or lost "due to an unexpected change

in family status." S. Rep. No. 99-146, 99th Cong., 2d Sess. 3, reprinted in 1986 U.S. CODE CONG. & ADMIN. NEWS 322.

Section 300bb-1(a) states:

" In accordance with regulations which the Secretary shall prescribe, each group health plan that is maintained by any State that receives funds under this chapter, by any political subdivision of such a State, or by any agency or instrumentality of such a State or political subdivision, shall provide, in accordance with this subchapter, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the

election period, continuation coverage under the plan."

A virtual mirror image of §§ 300bb-1 through 300bb-8 is found in the Internal Revenue Code, 26 U.S.C. § 162(k) with the prefatory tax language. Section 162(i)(2)(A) states:

" No deduction shall be allowed under this section for expenses paid or incurred by an employer for any group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of subsection (k)."

Excluded from the requirement of § 300bb-1(a) are employers with fewer than twenty employees and group health plans maintained by the government of the

District of Columbia or any territory or possession of the United States. 42 U.S.C. § 300bb-1(b)(1) and (2). To avoid a § 162(i) denial, "[t]he coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred." 42 U.S.C. § 300bb-2(1); 26 U.S.C. § 162(k)(2)(A); 29 U.S.C. § 1162(1) (emphasis added).[4] Section 300bb-

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[4] The Employee Retirement Income Security Act of 1974, 29 U.S.C. §1161, contains the same continuation coverage rules and identical provisions as found in the Public Health Service Act and the Internal Revenue Code. See, e.g., 29 U.S.C. § 1162(2), 100 Stat. 228.

3 defines a qualifying event in part for any covered employee[5]:

> " [T]he term "qualifying event" means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this subchapter, would result in the loss of coverage of a qualified beneficiary:
>
> (1) The death of the covered employee.

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[5] "The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer." 42 U.S.C. §300bb-8(2).

(2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment."

Unless there are multiple qualifying events, coverage must extend for at least eighteen months from the date of the qualifying event.

Subsection 300bb-8(3)(A) defines a qualified beneficiary eligible for continuation coverage. It states:

" The term "qualified beneficiary" means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan--

(i) as the spouse of the covered employee, or

(ii) as the dependent child of the employee."

In fact, § 300bb-8(3)(B) provides a special rule for terminations and reduced employment: "In the case of a qualifying event described in section 300bb-3(2) of this title, the term 'qualified beneficiary' includes the covered employee."

Failure to make a timely payment of the premium, 42 U.S.C. § 300bb-2(2)(C), or the employer's ceasing to provide any group health plan to any employee, 42 U.S.C. § 300bb(2)(B), will terminate the requirement to provide continuation coverage. In addition, continuation

coverage may end under § 300bb-2(2)(D)(i), which states:

> " The date on which the qualified beneficiary first becomes, after the date of the election --
>
> (i) covered under any other group health plan (as an employee or otherwise). . . ."

The present language of subsection (i) appeared in 1986 when Congress enacted the Tax Reform Act, Pub. L. No. 99-514, 100 Stat. 2085 (1986), which amended various provisions of COBRA.[6] Previously, § 300bb-2(2)(D)(i) read "a covered employee under

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[6] These amendments were made effective as if included in COBRA unless otherwise specified.

any other group health plan." A House Conference Report explained this language, "[a]s under the House bill and Title IX of the Senate amendment, no coverage need be provided after (1) failure to make timely payment under the plan, (2) the qualified beneficiary is covered under another group health plan as a result of employment, reemployment, or remarriage, and (3) the qualified beneficiary becomes entitled to Medicare benefits." H.R. 3128, 99th Cong., 1st Sess., 131 CONG. REC. 38,285-286 (1985).

The amended language thus attempts to clarify Congress' intention that continuation coverage must be provided to a qualified employee unless the employee is covered by virtue of his reemployment or otherwise changes marital status.

While the district court believed "or otherwise" included the then-existing coverage of the employee's spouse, it would appear that Congress intended this language to refer to subsequent events related to the employee's own employment or marital status. Section 300bb-2(2)(D)(i) specifies the coverage available "at the time of the qualifying event" would terminate only after the date of election when the beneficiary first becomes covered by another plan because of a change in job or marital status. Thus, a qualified beneficiary who receives coverage under the group health plan of an employer other than the employer providing the continuation coverage would no longer be eligible for continuation coverage. If a qualified beneficiary who is the spouse

of a covered employee remarries, the continuation coverage under the covered employee's plan would terminate.

Our interpretation of this subsection is generated by the nucleus of § 300bb-1 and its revenue counterpart. The essence of continuation coverage is that it is "identical" not only to that coverage which the employee had prior to the qualifying event but also to "the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred." 42 U.S.C. § 300bb-2(1). Thus, under this scheme, the spouse of a covered employee who might have some other insurance coverage could elect continuation coverage and pay the applicable premiums not to exceed 102% of

the premium cost. 42 U.S.C. § 300bb-2(3)(A). It is inconsistent then that Congress would deny the same election to the covered employee.

When we look at the subsequent debate over the continuation coverage rules, we are further convinced that Congress intended "any other coverage" to permit the employee to elect to maintain his prior coverage for a limited period of time so that a gap in coverage would not put him or his family at risk. That debate concentrated on two unresolved and contested areas: (1) the appropriate penalty for failure to satisfy the continuation coverage requirements of group health plans (see S. 2238 and H.R. 4845) and (2) those preexisting conditions which would permit a qualified beneficiary

to elect continuation coverage when the new plan excludes coverage of that preexisting condition. (See H.R. Rep. No. 100-801, 100th Cong., 2d Sess., pt. 2 (1988)). Subsequent amendments to Titles 26 and 29, the Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, 102 Stat. 3342 (1988), included the penalty for failure to provide continuation coverage.[7] The Act provided new coverage under ERISA which the accompanying Senate report explained.

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[7] Section 4980B(b) states in part: "(1) IN GENERAL. - The amount of the tax imposed by subsection (a) on any failure with respect to a qualified beneficiary shall be $100 for each day in the noncompliance period with respect to such failure."

" The bill deletes the provision allowing continuation coverage to be terminated upon the coverage of the qualified beneficiary under the group health plan of an employer other than the employer providing the continuation coverage.

This provision is intended to carry out the purpose of the health care continuation rules, which was to reduce the extent to which certain events, such as the loss of one's job, could create a significant gap in health coverage. The fact that a qualified beneficiary receiving group health coverage from another employer is willing to pay up to 102 percent of

the applicable premium for continuation coverage (which he or she may be required to pay by the employer providing the continuation coverage) is a strong indication that the significant gap in the qualified beneficiary's health coverage. This is especially true when the new employer group health coverage excludes coverage for a preexisting condition that is covered by the continuation coverage."

S. Rep. No. 100-445, 100th Cong., 2d Sess. 6, reprinted in 1988 U.S. CODE CONG. & ADMIN. NEWS 4955 (emphasis added).[8]

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[8] The provision was to apply to events occurring after December 31, 1988.

"Although subsequent legislative history is less authoritative than contemporaneous explanation, subsequent Congressional declaration of an act's intent is entitled to great weight in statutory construction." Roosevelt Campobello Int'l Park Comm'n v. United States Environmental Protection Agency, 711 F.2d 431, 436-37 (1st Cir. 1983) (citation omitted). While the contemporaneous legislative history does not specifically address the "covered under any other group health plan" question, we are satisfied the overall statutory scheme contemplates continuation coverage to remain available to the covered employee despite a spouse's other insurance. Indeed, the facts of this case illustrate the precise gap in coverage

which troubled Congress. Mr. Oakley was terminated because of a catastrophic event which otherwise would have put his family at risk and jeopardized his treatment had the continuation rules not been in effect to maintain his rehabilitation for a limited period of time.

In light of Congress' overriding intent to address the crisis in health insurance coverage in the workplace which is underscored in subsequent amendments and congressional history, we are persuaded that § 300bb-2(2)(D)(i) does not provide the basis to terminate continuation coverage under the circumstances of this case. Congress did not contemplate that a spouse's other coverage would nullify a covered employee's right to elect continuation coverage. The proposed

Treasury Regulations which have not yet been enacted do not alter our view.[3] Until the agency completes formal rule-making and promulgates rules that are the product of this adjudicatory process, the proposed rules are unpersuasive. See Woodstock/Kenosha Health Center v. Bowen, 810 F.2d 123 (7th Cir. 1987).

Based on our analysis of the statutory scheme, we conclude the district court erred as a matter of law in deciding § 300bb-2(2)(D)(i) terminated Mr. Oakley's eligibility to elect continuation coverage under the Plan. We therefore reverse the judgment and remand for entry of judgment

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[3] The Departments of Labor, Treasury, and Health and Human Services are authorized to promulgate rules to administer this program. To date, no agency has issued its final regulations.

in accordance with this opinion. The mandate shall issue forthwith.

**PUBLISH**

**UNITED STATES COURT OF APPEALS**

**FOR THE TENTH CIRCUIT**

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|---|---|
| JAMES OAKLEY, Plaintiff - Appellant, v. CITY OF LONGMONT and SAFECO INSURANCE COMPANY OF AMERICA, Defendants - Appellees. | FILED United states Court of Appeals Tenth Circuit December 8, 1989 Robert L. Hoecker Clerk No. 89-1021 |

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ORDER ON PETITION FOR REHEARING

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Before **MOORE**, **ANDERSON**, and **BRORBY**, Circuit Judges.

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Upon appellees' motion for rehearing, it is ordered that rehearing is granted. The mandate is recalled. Upon rehearing, the court's first opinion in the case, Oakley v. City of Longmont, 887 F.2d 249 (10th

Cir.1989), is withdrawn. The attached opinion is substituted in its place. The suggestion for rehearing en banc is denied without prejudice. The mandate is reissued forthwith.

Entered for the Court

JOHN P. MOORE, Circuit Judge.

**PUBLISH**

**UNITED STATES COURT OF APPEALS**

**FOR THE TENTH CIRCUIT**

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|---|---|
| JAMES OAKLEY, Plaintiff-Appellant, v. CITY OF LONGMONT and SAFECO INSURANCE COMPANY OF AMERICA, Defendants-Appellees. | FILED United states Court of Appeals Tenth Circuit December 8, 1989 Robert L. Hoecker Clerk<br><br>No. 89-1021 |

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Appeal from the United States
District Court
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D.C. No. 88-B-1204

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Submitted on the Briefs:

Mark E. Biddison and Andrew C. Littman of Stevens, Littman & Biddison, Boulder, Colorado, for Plaintiff-Appellant.

Claybourne M. Douglas, City Attorney, for Defendant-Appellee city of Longmont.

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Before **MOORE**, **ANDERSON**, and **BRORBY**, Circuit Judges.

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**MOORE**, Circuit Judge.

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After examining the briefs and appellate record, this panel has determined unanimously that oral argument would not materially assist the determination of this appeal. See Fed.R.App.P. 34(a); 10th Cir.R. 34.1.9. The cause is therefore ordered submitted without oral argument.

James Oakley sought a declaratory judgment that he was entitled to continue his medical insurance coverage under the health plan offered by his employer, the City of Longmont (the City), after he was

severely injured in an automobile accident. Resolving cross-motions for summary judgment, the district court granted the City's motion, finding that under 42 U.S.C. § 300bb-2(2)(D)(i), the City is not required to provide continuation coverage to its previously covered employee. Oakley v. City of Longmont, 701 F.Supp. 800 (D.Colo.1988). We reverse.

I.

Mr. Oakley was employed by the City as a fire fighter when he was involved in an automobile collision with a drunk driver and suffered a permanent head injury. As a City employee, Mr. Oakley was covered by the City of Longmont Medical and Dental Care Expense Reimbursement Plan, Plan No. 56690 (the Plan), which extended coverage

until his termination on August 27, 1988, and for an additional ninety days until November 26, 1988, as provided by the Plan. In July 1988, after an exchange of letters, the City informed Mr. Oakley that he was not eligible to maintain his medical insurance coverage for an additional eighteen months with the City's Plan because he is a dependent under his wife's group health plan. Nevertheless, on October 7, 1988, the Plan notified Mr. Oakley of his option to continue his prior medical coverage for eighteen months by maintaining the premium payments himself. Apparently, Mr. Oakley did not return the election form at that time because of his prior notification from the City that he was ineligible for continuation coverage.

Subsequently, Mr. Oakley submitted the form on November 21, 1988.[1]

At the time of his termination, Mr. Oakley was a patient at the Bear Creek Rehabilitation Center where he was receiving rehabilitation therapy for the brain injury he had suffered. Although he was listed as a dependent on his wife's group health plan, Mrs. Oakley's coverage does not reimburse the costs of this treatment. Consequently, Mr. Oakley sought declaratory and injunctive relief

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[1] In its opinion, the district court stated, "Because plaintiff has not yet elected continuation coverage, and because he is a dependent under his wife's policy, the City has not extended the plaintiff continuation coverage." Oakley v. City of Longmont, 701 F.Supp. 800, 801 (D.Colo.1988). The record, however, establishes that Mr. Oakley timely returned the election form. The City does not contest his eligibility on this basis.

to continue his medical coverage with the City. The district court, however, denied relief under 42 U.S.C. § 300bb-2(2)(D)(i), which states that continuation coverage ends on the date "the qualified beneficiary first becomes, after the date of the election--(i) covered under any other group health plan (as an employee or otherwise)...." The court cited accompanying legislative history which it believed manifested Congress' "beneficent purpose of requiring a minimal amount of continuation coverage for a limited time to provide qualified beneficiaries an opportunity to secure other health benefits." 701 F.Supp. at 801-02. However, relying principally on language in proposed regulations promulgated in the Federal Register by the Internal Revenue

Service,[2] which was delegated the authority to issue regulations defining required coverage, the district court concluded that Congress did not intend "to require employers to provide continuation coverage to qualified beneficiaries who are covered by more than one group health plan." Id. at 802. Mr. Oakley now appeals this conclusion, contending the court erred in construing the statute and

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[2] The proposed regulation states that continuation coverage must not end before "(d) the first date after the date of the election upon which the qualified beneficiary is covered (i.e., actually covered, rather than merely eligible to be covered) under any other group health plan that is not maintained by the employer, even if that coverage is less valuable to the qualified beneficiary than COBRA continuation coverage (e.g., if the other coverage provides no benefits for preexisting conditions)...." 52 Fed.Reg. 22730 (1987).

in relying on a proposed Treasury Regulation that has not yet been adopted.[3]

II.

In 1986, Congress passed the Comprehensive Omnibus Budget Reconciliation Act, Pub.L. No. 99-272, 100 Stat. 82 (1986) (COBRA), to address the "staggering budget deficits now facing the United States." S.Rep. No. 99-146, 99th Cong., 2d Sess. 3, reprinted in 1986 U.S.CODE CONG. & ADMIN. NEWS 42, 43. Conflated with its many revenue-related provisions is the statute at issue, 42 U.S.C. § 300bb-1, entitled "Requirements for certain group health plans for certain

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[3] Safeco Insurance Company of America is not a party to this appeal but has stipulated to being bound by the court's order.

state and local employees." Section 300bb-1 was spawned by Congress' concern "with reports of the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay." H.R.Rep. No. 99-241, Part I, 99th Cong., 2d Sess. 44, reprinted in 1986 U.S.CODE CONG. & ADMIN. NEWS 622. As one solution to the problem, Congress amended Section 162 of the Internal Revenue Code "to deny the business tax deduction for a group health plan of any employer who fails to include in the plan a continuation option" to the employee, his spouse, and dependent children. Id. Congress fashioned the tax incentive to insure that health benefits for certain workers would not be put at

risk or lost "due to an unexpected change in family status." S.Rep. No. 99- 146, 99th Cong., 2d Sess. 363, reprinted in 1986 U.S.CODE CONG. & ADMIN. NEWS 322. Section 300bb-1(a) states:

> " In accordance with regulations which the Secretary shall prescribe, each group health plan that is maintained by any State that receives funds under this chapter, by any political subdivision of such a State, or by any agency or instrumentality of such a State or political subdivision, shall provide, in accordance with this subchapter, that each qualified beneficiary who would lose coverage under the plan as a result of a

qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan."

A virtual mirror image of se 300bb-1 through 300bb-8 is found in the Internal Revenue Code, 26 U.S.C. § 162(k) with the prefatory tax language. Section 162(i)(2)(A) states:

" No deduction shall be allowed under this section for expenses paid or incurred by an employer for any group health plan maintained by such employer unless all such plans maintained by such employer meet the continuing coverage requirements of subsection (k)."

Excluded from the requirement of § 300bb-1(a) are employers with fewer than

twenty employees and group health plans maintained by the government of the District of Columbia or any territory or possession of the United States. 42 U.S.C. § 300bb-1(b)(1) and (2). To avoid a § 162(i) denial, "(t)he coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred." 42 U.S.C. § 300bb-2(1); 26 U.S.C. § 162(k)(2)(A); 29 U.S.C. § 1162(1) (emphasis added).[4] The

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[4] The Employee Retirement Income Security Act of 1974, 29 U.S.C. s 1161, contains the same continuation coverage rules and identical provisions as found in the Public Health Service Act at issue here and the

accompanying legislative history explains that identical coverage means, "(f)or example, if, under the plan, the covered employee had the right to select among several levels of coverage, the qualified beneficiary generally would be entitled to continue whatever level of coverage the employee had selected for the beneficiary prior to the qualifying event." S.Rep. No. 99-146, 99th Cong., 2d Sess. 366, reprinted in U.S. CODE CONG. & ADMIN. NEWS 325.

Section 300bb-3 defines a qualifying event in part for any covered employee [5]

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Internal Revenue Code. See, e.g., 29 U.S.C. s 1162(2), 100 Stat. 228.

[5] "The term 'covered employee' means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment

"(T)he term 'qualifying event' means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this subchapter, would result in the loss of coverage of a qualified beneficiary: (1) The death of the covered employee. (2) The termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment."

Unless there are multiple qualifying events, coverage must extend for at least

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or previous employment with an employer." 42 U.S.C. s 300bb- 8(2).

eighteen months from the date of the qualifying event.

Subsection 300bb-8(3)(A) defines a qualified beneficiary eligible for continuation coverage. It states:

> " The term "qualified beneficiary" means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan--
>
> (i) as the spouse of the covered employee, or
>
> (ii) as the dependent child of the employee."

A special rule for terminations and reduced employment underscores that a

qualified beneficiary includes the covered employee. 42 U.S.C. § 300bb- 8(3)(B).

With this statutory groundwork in place, we turn to the subsection at issue in this appeal, 42 U.S.C. § 300bb-2(2), the period of continuation coverage. Continuation coverage automatically terminates after the maximum period of coverage permitted, 18 months from the date of the qualifying event. 42 U.S.C. § 300bb-2(2)(A)(i). Otherwise, failure to make a timely payment of the premium, 42 U.S.C. § 300bb-2(2)(C), or the employer's ceasing to provide any group health plan to any employee, 42 U.S.C. § 300bb-2(2)(B), will terminate continuation coverage prior to the statutory deadline. In addition, continuation coverage ends on: The date on which the qualified

beneficiary first becomes after the date of the election--(i) covered under any other group health plan (as an employee or otherwise).... 42 U.S.C. § 300bb-2(2)(D)(i) (emphasis added). When we read the underlined introductory language in conjunction with "covered under any other group health plan (as an employee or otherwise)," we believe the plain meaning of this subsection cannot be construed to include a spouse's preexisting group plan as a condition to terminate continuation coverage. Indeed, Mr. Oakley did not "first become" covered under his wife's policy after the qualifying event that resulted in his termination from the City's employment. Nor did Congress intend a covered employee's termination to become a

condition triggering "other" coverage under a spouse's preexisting group plan. Consequently, only when we read the language of subsection (i) to refer to other coverage occurring after the qualifying event, do we preserve its plain meaning and give effect to Congress' intent.

Our interpretation is premised on contemporaneous congressional history and a reading of the statute as a whole. The accompanying House Conference Report explains the conference agreement on the duration of coverage provided to widows, divorced spouses, spouses of Medicare-eligible employees, dependent children who become ineligible, and for terminated employees:

" (a)s under the House bill and Title IX of the Senate amendment, no coverage need be provided after (1) failure to make timely payment under the plan, (2) the qualified beneficiary is covered under another group health plan as a result of employment, reemployment, or remarriage, and (3) the qualified beneficiary becomes entitled to Medicare benefits. H.R. 3128, 99th Cong., 1st Sess., 131 CONG.REC. 38,285-286 (1985) (emphasis added)."

Thus, continuation coverage will terminate if the covered employee becomes covered by another policy because he obtains new employment, is reemployed, or remarries. None of these conditions is present here. While the district court

believed "or otherwise" included the then-existing coverage of the employee's spouse, Congress intended this language to refer to subsequent events related to the employee's own employment or marital status. Consequently, a qualified beneficiary who receives coverage under the group health plan of a subsequent employer other than the employer providing the continuation coverage would no longer be eligible for continuation coverage. If a qualified beneficiary who is the spouse of a covered employee remarries, the continuation coverage under the covered employee's plan would terminate.

The subsection must be construed, moreover, in light of the entire legislative scheme in which this component operates. See 2A C. Sands, Southerland on

Statutory Construction § 46.05, at 90 (4th ed.1984). The essence of continuation coverage, as found in § 300bb-1 and its revenue counterpart, is that coverage must be "identical" not only to that coverage which the employee had prior to the qualifying event but also to "the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred." 42 U.S.C. § 300bb-2(1). Although the district court believed Congress was concerned with providing minimal coverage and avoiding overlapping continuation coverage, 701 F.Supp. at 802, the statute speaks only in terms of identical coverage to be made available for a limited time to a covered employee. Hence, under this scheme, if the spouse of

a covered employee could elect continuation coverage and pay the applicable premium not to exceed 102% of the premium cost, 42 U.S.C. § 300bb-2(3)(A), it is inconsistent that Congress would deny the same election to the covered employee.

Thus, while the contemporaneous legislative history does not specifically address the language at issue here, "covered (as an employee or otherwise)," we are satisfied that the overall statutory scheme contemplates continuation coverage to remain available to the covered employee despite a spouse's preexisting insurance policy. Surely the facts of this case illustrate the precise gap in coverage which troubled Congress. Mr. Oakley was terminated because of a

catastrophic event which otherwise would have put his family at risk and jeopardized his treatment had the continuation rules not been in effect to maintain his rehabilitation for a limited period of time.

In light of Congress' overriding intent to address the crisis in health insurance coverage in the workplace, we are persuaded that § 300bb-2(2)(D)(i) does not provide the basis to terminate continuation coverage under the circumstances of this case. The proposed Treasury Regulations on continuation coverage requirements of group health plans, on which the district court relied, do not alter our reading. Until the agency completes formal rule- making and promulgates final regulations, the

proposed rules, which the Internal Revenue Service has already deemed interpretive regulations, are unpersuasive. See Telvest, Inc. v. Bradshaw, 618 F.2d 1029, 1036, n. 10 (4th Cir.1980).

Based on our analysis of the statutory scheme, we conclude the district court erred as a matter of law in deciding § 300bb-2(2)(D)(i) terminated Mr. Oakley's eligibility to elect continuation coverage under the Plan. We therefore REVERSE the judgment and REMAND for entry of judgment in accordance with this opinion.

**UNITED STATES COURT OF APPEALS**

**FOR THE TENTH CIRCUIT**

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|---|---|
| JAMES OAKLEY, Plaintiff-Appellant, v. CITY OF LONGMONT and SAFECO INSURANCE COMPANY OF AMERICA, Defendants-Appellees. | No. 89-1021 |

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ORDER

Filed January 25, 1990

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Before HOLLOWAY, Chief Judge, McKAY, LOGAN, SEYMOUR, MOORE, ANDERSON, TACHA, BALDOCK, BRORBY and EBEL, Circuit Judges.

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This matter comes on for consideration of appellant's petition for rehearing and suggestion for rehearing en banc in the captioned cause.

Upon consideration whereof, the petition for rehearing is denied by the panel that rendered the decision sought to be reheard.

In accordance with Rule 35(b) of the Federal Rules of Appellate Procedure, the petition for rehearing and suggestion for rehearing en banc were transmitted to all the judges of the court in regular active service. No member of the hearing panel and no judge in regular active service on the court having requested that the court be polled on rehearing en banc, Rule 35, Federal Rules of Appellate Procedure, the

suggestion for rehearing en banc is denied.

Entered for the Court

/S/_____

ROBERT L. HOECKER, Clerk

## Statutes Involved

42 U.S.C. § 300bb-1. Provides, in pertinent part:

**300bb-1. State and local governmental group health plans must provide continuation coverage to certain individuals**

**(a) In general**

In accordance with regulations which the Secretary shall prescribe, each group health plan that is maintained by any State that receives funds under this chapter by any political subdivision of such a State, or by any agency or instrumentality of such a State or political subdivision, shall provide, in

accordance with this subchapter, that each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event is entitled, under the plan, to elect, within the election period, continuation coverage under the plan...

42 U.S C. § 300bb-2 Provides, in pertinent part:

**300bb-2. Continuation coverage**

For purposes of section 300bb-1 of this title, the term "continuation coverage" means coverage under the plan which meets the following requirements:

(1) Type of benefit coverage.

The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage is modified under the plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this part in connection with such group.

(2) Period of coverage.

The coverage must extend for at least the period beginning on the

date of the qualifying event and ending not earlier than the earliest of the following:

(2)(A) Maximum required period.

(2)(A)(i) General rule for terminations and reduced hours. In the case of a qualifying event described in section 300bb-3(2) of this title, except as provided in clause (ii), the date which is 18 months after the date of the qualifying event.

(2)(A)(ii) Special rule for multiple qualifying events. If a qualifying event occurs during the 18 months after the date of a qualifying event described in section 300bb-3(2) of this title, the date which is 36 months after

the date of the qualifying event described in section 300bb-3(2) of this title.

(2)(A)(iii) General rule for other qualifying events. In the case of a qualifying event not described in section 300bb-3(2) of this title, the date which is 36 months after the date of the qualifying event.

(2)(B) End of plan.

The date on which the employer ceases to provide any group health plan to any employee.

(2)(C) Failure to pay premium.

The date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required under the plan with respect to the qualified

beneficiary. The payment of any premium (other than any payment referred to in the last sentence of paragraph (3)) shall be considered to be timely if made within 30 days after the date due or within such longer period as applies to or under the plan.

(2)(D) Group health plan coverage or medicare eligibility. The date on which the qualified beneficiary first becomes, after the date of the election--

(2)(D)(i) covered under any other group health plan (as an employee or otherwise), or

(2)(D)(ii) entitled to benefits under title XVIII of the Social

Security Act (42 U.S.C. 1395 et seq.)...

42 U.S C. § 300bb-3 provides, in pertinent part:

**300bb-3 Qualifying event**

For purposes of this subchapter, the term "qualifying event" means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this subchapter, would result in the loss of coverage of a qualified beneficiary:

(1) The death of the covered employee.

(2) The termination (other than by reason of such employee's gross

misconduct), or reduction of hours, of the covered employee's employment.

(3) The divorce or legal separation of the covered employee from the employee's spouse.

(4) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(5) A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

42 U.S C. § 300bb-5 provides, in pertinent part:

**300bb-5 Election**

For purposes of this subchapter--

(1) Election period.

The term "election period" means the period which--

(1)(A) begins not later than the date on which coverage terminates under the plan by reason of a qualifying event,

(1)(B) is of at least 60 days' duration, and

(1)(C) ends not earlier than 60 days after the later of--

(1)(C)(i) the date described in subparagraph (A), or

(1)(C)(ii) in the case of any qualified beneficiary who receives notice under section 300bb-6(4) of this title, the date of such notice...

42 U.S C. § 300bb-7 provides, in pertinent part:

**300bb-7 Enforcement**

Any individual who is aggrieved by the failure of a State, political subdivision, or agency or instrumentality thereof, to comply with the requirements of this subchapter may bring an action for appropriate equitable relief.

42 U.S C. § 300bb-8 provides, in pertinent part:

**300bb-8 Definitions**

For purposes of this subchapter--

(1) Group health plan.

The term "group health plan" has the meaning given such term in section 162(i)(2) of Title 26.

(2) Covered employee.

The term "covered employee" means an individual who is (or was) provided coverage under a group health plan by virtue of the individual's employment or previous employment with an employer.

(3) Qualified beneficiary.

(3)(A) In general.

The term "qualified beneficiary" means, with respect to a covered employee under a group health plan, any other individual who, on the day

before the qualifying event for that employee, is a beneficiary under the plan--

(3)(A)(i) as the spouse of the covered employee, or

(3)(A)(ii) as the dependent child of the employee.

(3)(B) Special rule for terminations and reduced employment. In the case of a qualifying event described in section 300bb-3(2) of this title the term "qualified beneficiary" includes the covered employee...

Appendix 81a

**Regulations Involved**

52 Federal Register 22716 provides , in pertinent part:

PROPOSED RULES

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

(EE-143-86)

Income Tax;

Continuation Coverage Requirements of Group Health Plans

Monday, June 15, 1987

AGENCY: Internal Revenue Service, Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains proposed regulations relating to the

requirement that a group health plan offer continuation coverage to people who would otherwise lose coverage as a result of certain events. They reflect changes made by the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA) and the Tax Reform Act of 1986. The regulations will generally affect sponsors of and participants in group health plans, and they provide plan sponsors with guidance necessary to comply with the law.

DATES: Written comments and requests for a public hearing must be delivered or mailed on or before August 14, 1987. These regulations are proposed to be effective when

final regulations are published in the Federal Register as a Treasury decision.

...

SUPPLEMENTARY INFORMATION:

Background

This document contains proposed amendments to the Income Tax Regulations (26 CFR Part 1) under sections 106(b), 162(i)(2), and 162(k) of the Internal Revenue Code of 1986 (Code). The proposed regulations conform the regulations to section 10001 of the Comprehensive Omnibus Budget Reconciliation Act of 1986 (COBRA) (100 Stat. 222) and to section 1895(d) of the Tax Reform Act of

1986 (100 Stat. 2936), which made technical corrections to the COBRA provisions. COBRA added a new section 162(k) of the Code to specify continuation coverage requirements for employer-provided group health plans. In general, a group health plan must offer each "qualified beneficiary" who would otherwise lose coverage under the plan as a result of a "qualifying event" an opportunity to elect continuation of the coverage being received immediately before the qualifying event. A qualified beneficiary who properly elects continuation coverage can be charged an amount no greater than 102 percent of the "applicable premium."

The "applicable premium" is based on the plan's cost of providing coverage.

If a group health plan fails to comply with these continuation coverage requirements, the employer will be unable to deduct contributions made to that or any other group health plan (section 162(i)(2)), and certain highly compensated individuals will be unable to exclude from income any employer- provided coverage under that or any other group health plan (section 106(b)).

In addition, there may be non-tax consequences if a group health plan

fails to comply with parallel requirements that section 10002 of COBRA added to Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Title I of ERISA is administered by the Department of Labor. Governmental plans (as defined in section 414(d) of the Code) are exempt from both the tax and ERISA provisions. However, State and local governmental group health plans are subject to parallel requirements that section 10003 of COBRA added to the Public Health Service Act, which is administered by the Department of Health and Human Services.

The proposed regulations do not reflect section 9501 of the Omnibus Budget Reconciliation Act of 1986, which extended the COBRA continuation coverage requirements to certain individuals receiving retiree medical benefits from employers that are involved in bankruptcy proceedings. The changes made by that act will be addressed in a later issuance.

The proposed regulations clarify which plans must offer COBRA continuation coverage and the tax consequences of failing to do so. They also provide guidance on a variety of details, including the scope of the continuation coverage,

who is a qualified beneficiary, what is a qualifying event, how elections are made, and when payment must be made. Rules regarding computation of the applicable premium under section 162(k)(4) will be addressed in a later issuance.

...

Effective Date

The regulations are proposed to be effective when final regulations are published in the Federal Register as a Treasury decision. Group health plans become subject to the COBRA continuation coverage requirements at different times, however, depending on the plan year of a plan and whether the plan is a

collectively bargained plan. With respect to qualifying events that occur on or after the date that a plan became or becomes subject to those requirements and before the effective date of final regulations, the plan and the employer must operate in good faith compliance with a reasonable interpretation of the statutory requirements (i.e., title X of COBRA). For the period before the effective date of final regulations, the Internal Revenue Service will consider compliance with the terms of these proposed regulations to constitute good faith compliance with a reasonable interpretation of the statutory requirements (other than the

statutory requirements regarding the computation of the applicable premium or the treatment, under section 9501 of the Omnibus Budget Reconciliation Act of 1986, of certain bankruptcies as qualifying events, which are not addressed in these proposed regulations). Moreover, plans and employers will be considered to be in compliance with the terms of these proposed regulations if, between June 15, 1987 and September 14, 1987, they operate in good faith compliance with a reasonable interpretation of the statutory requirements and, from September 15, 1987 until the effective date of final regulations, they operate in compliance with the

terms of these proposed regulations. In addition, the Internal Revenue Service will not consider actions inconsistent with the terms of these proposed regulations necessarily to constitute a lack of good faith compliance with a reasonable interpretation of the statutory requirements; whether there has been good faith compliance with a reasonable interpretation of the statutory requirements will depend on all the facts and circumstances of each case.

...

The proposed amendments to 26 CFR Part 1 are as follows:

Appendix 92a

PART 1--(AMENDED)

...

Par. 3. A new § 1.162-26 is added immediately after § 1.162-25T to read as follows:

s 1.162-26 Continuation coverage requirements of group health plans.

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Duration of COBRA continuation coverage: Q&A-38 to Q&A-43

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List of Questions

...

Duration of COBRA Continuation Coverage

Question 38: How long must COBRA continuation coverage be available to a qualified beneficiary

Answer 38: Except for an interruption of coverage in

connection with a waiver as described in Q&A-35 of this section, COBRA continuation coverage that has been elected by a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates: (a) The last day of the maximum coverage period (see Q&A-39 of this section); (b) the first day for which timely payment is not made to the plan with respect to the qualified beneficiary (see Q&A-48 of this section); (c) the date upon which the employer ceases to maintain any group health plan (including successor plans); (d) the first date after the date of the

election upon which the qualified beneficiary is covered (i.e., actually covered, rather than merely eligible to be covered) under any other group health plan that is not maintained by the employer, even if that other coverage is less valuable to the qualified beneficiary than COBRA continuation coverage (e.g., if the other coverage provides no benefits for preexisting conditions); or (e) the date the qualified beneficiary is entitled to Medicare benefits under Title XVIII of the Social Security Act. However, a group health plan can terminate for cause the coverage of a qualified beneficiary receiving COBRA continuation coverage on the

same basis that the plan terminates for cause the coverage of similarly situated active employees with respect to whom a qualifying event has not occurred. For purposes of the preceding sentence, termination for cause does not include termination based on a failure to make timely payment to the plan. (See Q&A-48 of this section regarding timely payment.)

...

Lawrence B. Gibbs,

Commissioner of Internal Revenue.

J. Roger Mentz,

Assistant Secretary of the Treasury.

(FR Doc. 87-13366 Filed 6-10-87; 12:21 pm)